Encyclopedia on Early Childhood Development

Maltreatment (child)

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Table of contents

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Synthesis

How important is it?

Child maltreatment is comprised of all abusive or neglectful actions committed by adults against minors. Maltreatment can be classified into the five following types.

1. Physical abuse represents any deliberate use of physical force against a child that constitutes a threat to the child's health, development, and self-respect. The range varies from milder forms of violence (e.g., pushing and shoving) to more severe forms (e.g., strangling and hitting).
2. Child sexual abuse (CSA) encompasses any completed or attempted sexual act, including both contact and non-contact interactions, committed against a child by a caregiver.
3. Neglect involves failure to meet a child's basic needs, including physical, emotional, medical/dental, or educational needs; failure to provide adequate nutrition, hygiene, shelter; or failure to ensure a child's safety.
4. Emotional maltreatment includes caregiver actions that result in, or has the potential to result in adverse effects on the child's emotional health and development. Caregiver behaviour can take various forms on the part of the caregiver including: rejection, isolation, ignoring, terrorizing, corruption or exploitation.
5. Exposure to intimate partner violence (IPV) has also been considered a form of maltreatment because children who are exposed to IPV (also referred to as domestic violence) display similar problems as children who are the direct target of physical abuse.

Worldwide estimates reveal that approximately 40 million children are currently the victims of maltreatment, with neglect being the most commonly reported form. Recent increases in the reported rates of neglect and IPV exposure have been attributed to new powers and a wider scope of activity of professionals working with children, as well as their improved ability to detect maltreatment. In contrast, the reported rates of child sexual abuse (CSA) have been on the decline, but the reason is unclear; this may reflect an actual reduction, perhaps due to the success of prevention programs, but could also be attributed to an increasing reluctance of victims to report the abuse, or more restrictive criteria to identify CSA. In fact, a recent *meta-analysis* measuring the prevalence of CSA around the world, estimated nearly 13% of adults self-report as having been the victims of CSA, a rate which is 30 times higher than the one of official disclosures.

Child maltreatment in any form causes long-lasting harm to children's health and development, and in the United States alone carries a yearly estimated direct and indirect cost of over $100 billion in services to recognize the abuse, intervene, and address its detrimental effects.

What do we know?

Maltreated children are at risk for a multitude of health problems such as growth, development and chronic

physical and mental health conditions that extend into adulthood. Substance abuse and criminality in adolescence and adulthood are also frequently observed in these individuals. The effects of maltreatment and associated risk factors vary as a function of the type of child maltreatment.

Physical abuse

The most direct consequences of physical abuse are injuries, serious ones involving head trauma and damage to internal organs; injuries such as bruises visible on the skin are the most common ones. Poverty, single-parent family, early pregnancy, domestic violence, and mental health problems are all considered environmental risks for this form of abuse. Although physical abuse is most frequent in older children, deaths caused by physical abuse are much higher in infancy and toddlerhood. The rate of death increases when the child lives with an unrelated adult, but overall has been consistently dropping over the past three decades.

Child sexual abuse (CSA)

Although clinical symptoms of CSA are not apparent in 1/3 of victims at the time the abuse is reported, CSA victims are at risk of experiencing mental health problems, including post-traumatic stress disorder, depression, substance abuse and dissociative symptoms (feeling that one's conscious experience is disconnected from one's environment, body, or emotions). Risky unprotected sex is also common among victims. In adulthood, CSA victims often continue to deal with mental health problems, are prone to involvement in violent relationships, and women are 2 to 3 times more likely to be sexually assaulted. Girls experience a twofold risk of CSA compared with boys, but this may be because boys are reticent to disclose the abuse. CSA occurs more frequently among adolescents between 12 and 17 years of age, though girls tend to be molested at a younger age and for longer than boys. Support from the parent who is not the perpetrator and no prior history of abuse have been identified as protective factors that can help children cope with the abuse.

Neglect

Unlike abuse, neglect is typically not committed intentionally, and often results from problems that impair a parent's ability to meet a child's needs. However, the negative consequences of neglect can be as damaging as those of abuse, especially when it is severe, chronic, and when it occurs early in life. Neglected children are at-risk for experiencing physical and mental health problems. In preschool and school-age children, social withdrawal, negative peer relations, academic difficulties, and depression are more common among neglected children relative to abused victims. As adults, they show similar risk of involvement in violence relationships compared with those who were physically abused.

Emotional maltreatment

This form of maltreatment is difficult to determine and document as it is less visible in its impact. Children exposed to emotional maltreatment can experience chronic stress that leads to physical and/or emotional impairment, such as risk behaviours (e.g., alcohol abuse) and early and persistent psychiatric disorders.

Exposure to intimate partner violence (IPV)

Even when exposure to IPV does not lead to clinical maladjustment, it may cause small distortions (ex.

favorable attitudes toward violence) that predispose children to experience more severe problems later on (e.g. believing that one is the cause of domestic violence, becoming violent themselves). Compared to children in non-violent households, those exposed to IPV are more aggressive and anxious, and they experience more problems with peers and at school. Children under 5 years of age are the most likely to be exposed to IPV because domestic violence is more common among couples with children in this age group. Unfortunately, these children are particularly vulnerable to the damaging effects of IPV because of their restricted coping skills and understanding of conflict.

What can be done?

Prevention and intervention

The key to reduce child maltreatment is a strong focus on prevention. Strategies used to prevent the occurrence of maltreatment have been grouped into three major categories.

1. Prevention before occurrence; these include universal and targeted programs. The best evidence is for the Nurse Family Partnership, an intensive program of nurse home visitation provided to first-time socially disadvantaged mothers. Another home visiting program – Early Start – and a parenting program – Triple P – are promising, but need further evaluation to determine their effectiveness. Hospital-based educational programs to prevent abusive head trauma are also promising, but need further study. Enhanced pediatric care for families of children at risk of physical abuse and neglect is also promising, but requires further assessment.
2. Prevention of recurrence is much more challenging; one program - Parent-Child Interaction Therapy, has shown benefits in reducing the recurrence of physical abuse, but not neglect. It is considered promising and needs further study.
3. Prevention of impairment programs, especially cognitive-behavioural therapy that focuses on reducing deficits in victims, can improve the well-being of sexually abused children who present with post-traumatic stress disorder symptoms. Interventions that target cognitive-emotional components have shown to yield better cognitive outcomes (e.g., memory) in children exposed to emotional maltreatment.

Transferring children to foster care can also enhance children's mental and physical health, and provide better outcomes in the behavioural, social and academic realms. Transition from the home (e.g., quality preschool experiences, school entry) provides emotionally-abused children with opportunities to realign their emotions.

Given that financial difficulties put children at risk for maltreatment, fighting poverty can go a long way in promoting children's safety. In addition, policies on employment flexibility can help parents establish a healthy balance between their home and job responsibilities. Strategies should also be implemented to encourage children and family members to disclose and report child maltreatment. Promoting coping and resilience in contexts of adversity is important.

Professionals working with children can contribute to making reduction of child maltreatment a priority. Abuse should always be considered in the assessment of children presenting with injuries or mental health problems. Trained workers should also become familiar with the cultural context in which children grow up to ensure that

children's needs for safety, nurturance and protection are met no matter what the cultural practices. Interventions to help maltreated children and neglectful families should also be guided by a common set of standards:

- Identify who and what contributes to the problems;
- Build a therapeutic alliance with the family;
- Set reasonable and concrete goals in collaboration with the family;
- Supervise the situation with care, and modify the plan as needed;
- Ensure that the needs of children are met;
- Collaborate with other professionals involved.

Child Physical Abuse: An Overview

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Introduction

The social environment in which children live has a profound effect on their health and well-being. For children around the globe, few social problems cause greater harm to their health than child abuse and neglect. Regardless of the type of maltreatment perpetrated against a child, the potential for lifelong physical and emotional consequences is significant.[1] Although seemingly straightforward, the definition of physical abuse is variable. Child physical abuse has been defined by the World Health Organization as the intentional use of physical force against a child that results or has a high likelihood of resulting in harm for the child's health, survival, development or dignity.[2] Legal definitions of physical abuse typically require physical harm to have occurred; governmental definitions of abuse and neglect are not uniform. Some definitions of physical abuse do not include perpetrator intent; others reflect motive rather than injury type.[3] Additionally, definitions of physical abuse are culturally determined, and what is considered abusive in one society may not be in another.[4,5] In many societies, physical violence against children as a method of punishment is endorsed by parents, sanctioned by societal institutions (such as schools) and allowed by law.

Quantifying the burden of child physical abuse is difficult. In addition to the definitional challenges, in many countries, epidemiologic data are not collected, and in those countries that monitor child maltreatment, official reports do not reflect the true prevalence.[6-8] Measuring physical abuse is methodologically challenging, and incidence and prevalence will vary by the surveillance methods used to define and detect the problem.[9] Many maltreated children are not brought to the attention of public agencies, and are not counted in official statistics. Even when abused children are brought to the attention of health or child welfare professionals, the abuse may be unrecognized or ignored by those in a position to protect the child.[10,11] Review of the best available research estimates that global prevalence of maltreatment by self-report is 226/1,000 children and approximately 125/1,000 for American children.[12,13] Lifetime risk of confirmed maltreatment for American children is estimated to be greater than 1 in 10.[14]

Child abuse results from a complex interaction of individual, family and societal risk factors. A number of variables are traditionally thought to increase the risk for child physical abuse. These include poverty, substance abuse, single parenthood, household composition, young maternal age, parental depression or other mental illness, and exposure to intimate partner violence.[15-20] A risk factor may impact families independently or risk factors may accumulate toward a threshold increased risk for physical abuse.[21] Risk factors for specific types of physical abuse have also been documented. For example, men more commonly perpetrate abusive head trauma, and rates of fatal child abuse are exceptionally high for young children who live in households with an unrelated adult in the home.[22,23] Although the association of some of these risk factors and child maltreatment is clear, risk factors should be considered broadly defined markers, rather than strong individual

determinants of abuse. Understanding the epidemiology of child abuse is important for developing governmental policies and intervention and prevention strategies. However, the individual professional cannot rely on population-based risk factors in determining whether a child before him or her is a victim of physical abuse.

Consequences of Child Physical Abuse

Victims of abuse are at high risk for poor health, related not only to the physical trauma they have endured, but also to high rates of other social risk factors associated with poor health.[24] Abused children have high rates of growth problems, untreated vision and dental problems, infectious diseases, developmental delay, mental health and behavioural problems, early and risky sexual behaviours, and chronic illnesses, but child welfare and health care systems historically have not addressed the health needs of dependent children.[25-30] Compared to children in foster care, maltreated children who remain at home exhibit similarly high rates of physical, developmental and mental health needs.[31]

Child physical abuse takes many forms, and patterns and severity of injury vary by age of the child. Although physical abuse is more common among older children, the youngest victims ? infants and toddlers ? have the highest rates of mortality from physical abuse.[32] They are the most vulnerable because of their physical and developmental immaturity, and relative social invisibility.[2] Morbidity from physical abuse is high in young victims of physical abuse, reflecting both the physical consequences of trauma to the small child and the developmental and emotional effects of early childhood trauma on the developing brain.

The public health consequences of child physical abuse are sizeable, and extend into adulthood. Retrospective and prospective studies have identified strong associations between cumulative traumatic childhood events, such as child maltreatment and family dysfunction, and adult physical disease, such as heart disease, liver disease, autoimmune diseases, sexually transmitted infections, and early death.[33-37] Mental health disease and the use of psychotropic medications are also greater in adults who had been maltreated as children.[38-40]

Scientific investigation is improving our understanding of the causal biological pathways for these robust associations.[41] Early childhood trauma, including physical abuse, leads to the production of stress hormones, such as cortisol and adrenaline that are normally protective, but with severe or persistent trauma can become toxic.[42,43] These stress hormones regulate neural circuits that are important in modulating an individual's response to stress, and over time, are associated with structural and functional changes in the brain and other organs. Influenced further by epigenomes, these changes are linked with impairment in the child's ability to respond to future biological and environmental stress, and increase the risk for physical and mental health disease later in life.[44,45] This research underscores the need to develop and test prevention and early intervention strategies for children who have been victims of serious physical abuse.

Recognition of Physical Abuse

Injuries that result from abuse are not always obvious or diagnostic, and identifying child physical abuse can be challenging. The history provided by the parent or other responsible adult may be inaccurate, either because the adult is unaware of the actual history, or is unwilling to provide a truthful history. There are many potential barriers to providing a truthful history that may include circumstances when the caregiver is the perpetrator of

intentional abuse, the caregiver is fearful of consequences related to a plausible accident, or the caregiver is fearful for their own safety with regard to disclosing abuse by another adult. Victims of serious physical abuse are often too young or too ill to provide a history of their assault, and if older, may be too frightened to do so. Injuries to non-ambulatory infants, those that are not explained by the reported history, multiple or patterned injuries, and injuries to multiple organ systems should always raise the possibility of abuse. Abusive injuries to children are most commonly found on the skin, but the most serious injuries occur to the brain, abdomen and other internal organs.[46,47] No single injury is diagnostic of abuse, but certain patterns of trauma can be highly specific for maltreatment. It is important to recognize that there is a differential diagnosis for every potential injury, and objective and thorough evaluation is required in order to identify abuse with reasonable confidence.[48,49]

Implications for Policy

Child physical abuse is a pervasive social problem. Child welfare agencies in the U.S. receive more than four million reports of suspected maltreatment annually and investigate approximately two-thirds of the reports made.[32,50] At any given time, more than 400,000 American children reside in foster care.[51] Despite the documented direct effects of physical abuse on the health of children, the recognition that early childhood trauma is a leading predictor of adult morbidity and early mortality, and the enormous indirect costs of funding the social and legal systems required to investigate abuse, protect children, hold perpetrators accountable and treat affected families, available public resources struggle to adequately address the problem.[52]

Child welfare services are historically structured as short-term interventions that monitor families for recidivism, provide targeted parenting education and assist with referrals to community-based services. The focus is on prevention of abuse recurrence, with less emphasis on prevention of child and family impairment, all of which are important measures of outcome. Little research has addressed treatment to improve children's impairment after physical abuse, but a few programs, such as Parent-Child Interaction Therapy, have shown promise in preventing the recurrence of child physical abuse.[53,54]

The argument for primary prevention and early identification and treatment is compelling, but children have no political capital, and solutions require comprehensive programs with collaboration between child welfare, law enforcement, courts, health and education. The evidence-base for child abuse prevention is growing yet there are still limited rigorous studies that show significant impact.[55-57] Programs that show promise are discussed in the Child Maltreatment Prevention paper by Professor Jane Barlow.[58]

Preventing the physical abuse of children and protecting them from further harm continues to require a public health approach. Reducing rates of maltreatment, supporting struggling families and improving pediatric and adult outcomes for victims requires community-wide strategies, with collaboration between child welfare, judicial, education, health and mental health colleagues to advocate for programs that are adequately tested and shown to be effective. Finally, reducing the toll of child abuse will only come when policy-makers embrace the belief that an ounce of prevention is truly better than a pound of cure.

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Child Neglect: An Overview

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Introduction

Neglect is by far the most common form of child maltreatment reported to the U.S. child welfare system; 75% of reports in 2017 were for neglect.[1] The short- and long-term outcomes associated with neglect are often serious, including fatalities, physiological changes in the brain, academic difficulties, criminal behaviour and mental health problems. In 2017, 75% of deaths attributed to child maltreatment involved neglect.[1] Furthermore, child neglect places an enormous economic burden on society. A conservative estimate regarding the costs associated with child maltreatment exceeded 100 billion dollars a year; much of this was for neglect.[2]

Subject

In general, the child welfare system considers neglect when there are parental omissions in care that result in actual or potential harm. An alternative approach focuses on children's unmet needs, acknowledging the many possible contributors (e.g., lack of access to health care), as well as parental behaviour.[3] The latter approach fits with the developmental ecological perspective which posits that no one factor alone contributes to neglect; there are multiple and interacting contributors at the level of the child, parents, family, community and society.

Neglect often does not involve one discrete act. Rather, it is a pattern of care that falls on a continuum ranging from optimal, where a child's needs are fully met, to extremely harmful, where a child's needs are not met at all. In addition, given that neglect naturally varies in type, severity and chronicity, it is clearly a very heterogeneous phenomenon.

A child-focused definition of neglect offers several advantages.[3] First, rather than blaming parents, a child-focused definition draws attention to children's basic needs (e.g., getting enough food). Second, given that most neglected children remain with their caregivers, a child-focused approach allows for a more collaborative relationship between professionals and caregivers. Lastly, this approach reflects ecological theory which recognizes that there are multiple interacting factors that contribute to neglect; it is not simply about parents who don't care about their children.

Intentionality. When children are neglected, it is not usually the case that their parents intend to do so. Rather, a variety of problems may impede their ability to adequately care for their child. As a practical matter, intentionality is difficult to assess and is therefore not useful in addressing neglect. Indeed, it may be harmful if considering neglect to be intentional leads professionals and others to be angry toward neglectful parents.

Culture. Research suggests that there is a remarkable level of agreement regarding what members of different communities define as neglect. For example, few differences have been found when examining the views of

African Americans and Whites, rural and urban adults, and low- and middle-income people as to what constitutes minimally adequate care for children.[4,5] Similarly, the United Nations Convention on the Rights of the Child offers remarkable testimony to what diverse countries and societies consider to be the basic needs or rights of children. Only one country, the United States, has not ratified the Convention. Nonetheless, myriad parenting practices across cultures do exist. These need to be understood and carefully assessed before conclusions regarding neglect are drawn.[6]

Problems: Effects of Neglect on Children

Child neglect can have severe detrimental effects on children's physical health, psychological well-being, cognitive and academic abilities, and social development. The severity, timing and chronicity of neglect influence the extent to which children are negatively impacted. Children's development is cumulative in nature, such that children's ability to accomplish new developmental tasks builds upon achievement of previous developmental milestones. Children who are neglected early in life may suffer impairment and thus struggle with subsequent developmental tasks.[7]

Research also suggests that the consequences of neglect are as detrimental as those of physical abuse. For example, in one study, neglected children had a smaller corpus callosum relative to a comparison group.[8] Compared to their non-maltreated peers, children in another study who experienced emotional neglect early in life performed significantly worse on achievement testing during the first six years of schooling.[9] Furthermore, although both abused and neglected children performed poorly academically, neglected children experienced greater academic deficits relative to abused children.[10] These cognitive deficiencies also appear to be long lasting. In a longitudinal follow-up study, adults abused or neglected in childhood performed poorly on tests of intelligence and reading ability compared to adults without a history of abuse or neglect.[11]

Neglected children often also struggle socially. In preschool and during middle childhood, neglected children are more likely to be socially withdrawn and experience negative interactions with their peers.[9,12] Additionally, neglected children may have significant internalizing problems such as withdrawal, somatic complaints, anxiety and depression when compared to physically-abused and sexually-abused children.[7] Similar to adults with a history of physical abuse, adults with a history of neglect are at increased risk for violent criminal behaviour.[13]

Contributors to Child Neglect

Multiple and interacting factors contribute to the occurrence of child neglect. Belsky's[14] developmental-ecological framework highlights three contexts in which child maltreatment is embedded: 1) the developmental-psychological context, which includes parent and child characteristics, parental developmental history, and intergenerational transmission of child maltreatment; 2) the immediate interactional context, which includes parenting behaviours and patterns of parent-child interactions; and 3) the broader context, which includes community and social support, socio-economic status, neighbourhood context, social norms and cultural influences. Importantly, these factors often interact and no one pathway to child neglect exists.

Identification of Neglect

Identifying neglect should be guided by specific state laws, whether the child's basic needs are unmet, and

whether potential or actual harm are involved.[15] Examples of unmet basic needs include inadequate or delayed health care, inadequate nutrition, inadequate physical care (e.g. poor personal hygiene, inappropriate clothing), unsafe or unstable living conditions, inadequate supervision and inadequate emotional care. A comprehensive assessment is needed to understand the nature and context of neglect and the contributing factors. This understanding helps guide the most appropriate intervention.

Cultural practices are an important consideration when assessing possible neglect. Terao and colleagues[16] offer a six-step decision-making model useful in differentiating child maltreatment from culturally-based parenting practices. Understanding the cultural context of families will also help inform clinicians on how to best respond.

Prevention and Intervention

A variety of approaches appear promising in helping to prevent neglect. Specific home visitation programs, especially with nurses supporting parents prenatally and then after the baby is born, have been carefully evaluated.[17-19] Parenting programs also offer valuable guidance and can be effective, such as the Triple P intervention.[20] Another example is the Safe Environment for Every Kid (SEEK) model of pediatric primary care.[21] Building on the relationship between pediatrician and family, SEEK identifies and helps address prevalent risk factors such as parental depression and intimate partner violence. All these interventions aim to strengthen families, support parents and parenting and promote children's health, development and safety.

For families where neglect has already occurred, interventions aim to prevent recurrences as well as the harmful outcomes that may follow. SafeCare is an example of an intervention that may reduce recidivism.[22] The specific intervention needs to be tailored to the needs and strengths of the individual child and family. The circumstances naturally vary greatly, but some core principles include: 1) address the contributors to the problem, 2) forge a helping alliance with the family, 3) establish clear achievable goals and strategies for reaching these goals, with the family, 4) carefully monitor the situation and adjust the plan if necessary, 5) address the specific needs of neglected children and those of other children in the home, and 6) ensure that interventions are coordinated with good collaboration among the professionals involved.

Advocacy

Advocacy regarding neglect may be at several levels as outlined in the following examples: 1) at the child's level, for example, explaining to a parent that responding to a crying infant does not risk spoiling him/her is a form of advocacy on behalf of a preverbal child; 2) at the parental level, helping a depressed mother access mental health care or encouraging a father to be more involved in his child's life; 3) at the community level, supporting efforts to develop community family resources; and 4) at the societal level, supporting government policies and programs such as those that improve access to health care, food benefits, and subsidized child care.

Implications for Policy

There are many governmental policies that can help prevent neglect; reducing poverty and its many associated burdens is paramount. It is the biggest risk factor for compromising children's health, development and safety. Other policies are needed to ensure adequate resources for addressing the main risk factors for neglect.

Flexible employment policies that enable mothers and fathers to better balance work with the demands of parenting are much needed. A final example is the need for disseminating evidence-based parenting programs. These are sorely needed to help prepare and guide many parents who struggle to meet their children's basic needs.

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Emotional Maltreatment

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Introduction

Emotional or psychological maltreatment is a highly prevalent and damaging form of child abuse. It reflects a caregiver's failure to provide a developmentally-appropriate and supportive environment, including persistent, pervasive or patterned dehumanizing acts such as frequent name-calling (emotional abuse; acts of commission) and failures in providing nurturance, affection, and approval (i.e., emotional neglect; acts of omission). Six types are recognized: (1) rejecting (e.g., constant criticism, belittling); (2) isolating (e.g., keeping family and friends from child); (3) ignoring (e.g., non-responding to child attentional bids, achievements etc.); (4) terrorizing (e.g., threatening abandonment or harm); (5) corrupting (e.g., child involvement in or exposure to criminal activities); and (6) exploiting (e.g., assigning caregiver role to child for parental care or childcare).[1] Some jurisdictions also categorize exposure to adult intimate partner violence (IPV) as a form of child emotional abuse. In this series, children's exposure to IPV is considered as a separate category of child maltreatment. Experiencing emotional maltreatment is strongly associated with the experience of other forms of childhood maltreatment and household dysfunction.[2] Unlike other forms of maltreatment, which may have physical indicators, emotional maltreatment has none. In sum, emotional maltreatment may be a stand-alone form of abuse or neglect, as well as a frequently co-occurring form.[1]

Prevalence and Under-Reporting

Different estimates of emotional maltreatment prevalence arise from research with different populations. A review of meta-analyses estimates the global prevalence of emotional abuse as 36.3% of people affected, and emotional neglect as 18.4% of people affected.[3] Studies of youth involved with Child Protective Services (CPS) have found that emotional maltreatment tends to occur much more frequently than what is recorded by CPS workers. In one study of CPS-involved cases that involved coding maltreatment experiences with a standard framework, over 50% of youth had experienced emotional abuse (chiefly terrorizing); the majority had also experienced physical abuse and neglect.[4] The Ontario Incidence Study of Reported Child Abuse and Neglect placed the 2013 CPS substantiation rate for emotional maltreatment rate at 13%, and the exposure to IPV at 48%.[5] Researchers found that 30% of cases where emotional maltreatment was the primary form had more than three prior case openings for some form of maltreatment.[6] The U.S. CPS-involved youth longitudinal study (LONGSCAN) found that 98% of youth who reported emotional maltreatment, reported re-experiencing it.[7] Exposure to early emotional maltreatment, number of CPS reports, and having a caregiver with depression were factors shown to predict entry into the foster care system.[8]

Subject

Recent longitudinal research found that maternal negative expressiveness mediated the relationship between mother's own emotional maltreatment experiences and their infant's emotional dysregulation and behavioral problems, in children as young as 14 months.[9] Parents who direct intense negative emotions towards the child (disgust, anger) or create highly negatively charged environments (yelling, being over-controlling) risk overwhelming their child's cognitive capacities and creating disorganized behavioural responses. This dynamic of parental ignore/attack and child destabilization creates a trajectory of impairment in managing emotions related to self and others. Research has shown that parents who perceive themselves as powerless, have both higher emotional reactivity and hostility towards their child's behaviour. In response to perceived child personal attack or personalization of disobedience, the parent responds with power assertive actions (rejection, attack).[10] Not surprisingly then, emotional maltreatment has been linked to significant impairment in emotion regulation, including difficulties with both emotional clarity (i.e., being able to identify one's emotions) and emotional expressiveness.[11-14] Emotional maltreatment-related impairment spans a wide range of mental health areas, including personality problems, mood disorders, substance abuse problems, and relationship violence.[2,15,16] A systematic review showed increased risks impacting school achievement (impulsivity, inability to pay attention, reduced literacy, and numerical skills difficulties).[16] Emotional maltreatment is associated with social anxiety and anxiety disorders[17-20] and depression.[21-24] Emotional neglect has been associated with drug-use and smoking,23 as well as binge drinking, alcohol abuse, and other alcohol-related problems.[25] There is some evidence of greater mental health impact of emotional maltreatment in adolescence on male victims.[26] Experiencing emotional abuse is predictive of aggression symptoms, however, there may be gender differences in the pathway from maltreatment to aggression. For example, one study found that this relationship was mediated by psychoticism in males, and neuroticism in females.[27] In a study of male youth offenders, maternal warmth mediated the relationship between emotional neglect and youth presenting with callous unemotional traits.[28]

Longitudinal research has identified the experience of emotional maltreatment over the course of a three-year period as a significant predictor of youth suicide ideation.[29] A nationally representative U.S. study found that adolescents who reported child emotional abuse were 2.6 times more likely to report suicidal ideation, and 2.4 times more likely to report a suicide attempt in the past year than those who had not experienced emotional abuse.[30] A core insult may be to the victim's sense of mattering (i.e., to one's self, to others, and to the environment), with emotional maltreatment linked with low levels of mattering.[31]

Another potential area of impairment for victims of emotional maltreatment is in building and maintaining positive relationships. A systematic review of the literature on adolescent victims of emotional maltreatment identified associations to both perpetration and victimization of IPV in males.[32] For CPS-involved youth, emotional maltreatment predicted dating violence perpetration in adolescent males and victimization in females, both of which were explained in part by the level of trauma symptomatology.[15] Similarly, emotional maltreatment predicted risky sexual behaviour at age 18, mediated in part by trauma symptoms.[33] The link between childhood emotional maltreatment and later decreased life satisfaction was mediated by rejection sensitivity in romantic partnerships in males.[34] For females, emotional maltreatment has been shown to significantly predict low relationship satisfaction.[35] Similarly, results from the U.S. Longitudinal Study of Adolescent to Adult Health found that experiencing emotional abuse was significantly related to adult perpetration and victimization of IPV in males, and perpetration and mutually-perpetrated violence in females.[36] Emotional maltreatment in childhood appears to be a robust disruptor of functioning in close relationships.

Finally, there is some evidence that children who have been victims of emotional maltreatment may be at risk of disordered eating behaviour and relationships in adolescence and adulthood. Kimber and colleagues conducted a systematic review finding the prevalence of emotional maltreatment, including IPV exposure, as it relates to eating disorders ranging from 21% to 66%.[37] A study of obese adults found that those with binge eating disorder reported significantly higher levels of emotional abuse and neglect.[38] In a large non-clinical study, emotional abuse was a significant positive predictor for hoarding of material possessions.[39]

Problems

1. Prevalence of emotional maltreatment is high.
2. While there is emerging consensus on (a) patterned caregiver behaviour defining emotional maltreatment, and (b) parental risk factors (depression, substance abuse, psychiatric illness in general, and a history of maltreatment), there is no agreement as to how to operationalize emotional maltreatment for practical use in terms of community standards for reasonable parenting.[40,41]
3. Existing parenting programs have some content relevant to emotionally maltreating caregiving (e.g., planned attention, positive time or time-in); prevention of emotional maltreatment has not yet been a focus in child welfare or public health, although IPV has in both systems.[42,43]
4. Sex may be a factor in understanding the emotional maltreatment–impairment link. Impact across the gender spectrum remains to be considered further.
5. A 2011 review determined further research was needed to develop a reliable and valid instrument to measure childhood emotional maltreatment.[44] Clinicians are encouraged to ask children about their family relationships, feelings of self-worth, being loved and safety.

Research Context

Most information on emotional maltreatment, as it relates to youths receiving CPS services comes from countries with formal child protection systems. When a case of emotional maltreatment is substantiated, it means the child welfare authorities investigated the allegation and deemed it to be of sufficient seriousness. The services provided could range from investigation only to child counseling to out-of-home placement for

alternate caregiving.

Key Research Questions

1. How does emotional maltreatment reflect a cycle of violence?
2. Are there emotional maltreatment indicators that signal greater risk for impairment or factors promoting resilience?
3. How does emotional maltreatment relate to gender diverse youth experiences?

Recent Research Results

A recent meta-analysis of studies involving parents committing emotional abuse found that emotionally abusive parents typically reported negative affect, depression, verbal aggression, emotion dysregulation and anger, as well as low levels of emotional control and positive coping strategies.[45] These results draw attention to the issue of intergenerational transmission of risk, as well as the need to emphasize intervention to bolster positive coping or parenting resilience.

A recent focus of attention has been the cognitive functioning and development of maltreated children.[46] For example, among foster children (in out-of-home care), a history of emotional abuse was negatively correlated with height-for-age, visual-spatial processing, memory, language and executive function.[47] Early intervention that targets environmental enrichment shows promise in yielding better child cognitive outcomes (e.g., memory) that seem to be mediated by the child's stress response hormones.[48] The ultimate goal is to consider the contexts for resilient functioning, integrating streams of biological, clinical and epidemiological research, with prevention.[49]

To date, it appears that there have been no studies looking at how concepts of heteronormative discrimination and social stigma may relate to emotional maltreatment among LGBTQ2SI+ youth. One recent study found that gay, lesbian, and bi-sexual adults who had experienced childhood emotional maltreatment had significantly higher levels of depression and anxiety symptoms as compared to those not experiencing familial emotional maltreatment.[50]

Research Gaps

Legal and medical definitions to guide CPS thresholds for intervention vary across regions, despite the clear need for CPS to accord more attention to emotional maltreatment impacts.[49] Presently, there is no "gold standard" approach to determine exposure to emotional maltreatment. In 2012, the American Academy of Pediatrics published a clinical report emphasizing the need for clinicians to be alert for this form of maltreatment, and consider interventions that promote positive parenting and child development, emphasizing the priority of child safety includes both physical and psychological safety.[51] A gap area relates to the rise of e-communications and the issue that emotional maltreatment may be perpetrated over the internet or via social media by family and others.

It is also important to examine how the effects of emotional maltreatment occur beyond caregiver/family dynamics. Recent research has examined the effects of emotional maltreatment on students by their teachers.[52]

One study of Korean youth reporting that 18.2% had experienced emotional maltreatment committed by their teacher,[53] and another study from the Republic of Cyprus reporting that 33.1% of students surveyed had been emotionally abused by a teacher in primary school.[54] As complex as it may be to define and identify familial emotional maltreatment, it becomes increasingly complicated to detect emotional maltreatment occurring outside of the home.

Conclusions and Implications for Parents, Practice and Policy

Emotional maltreatment is a prevalent, but less visible form of childhood maltreatment. The implications for parents, practice and policy is: (1) a consideration of the home emotional climate, emotional literacy and the provision of experiences where there is a dominance of positive over negative emotions; (2) to prevent the occurrence of child maltreatment including exposure to adult IPV; (3) to adequately promote the safety, well-being and rights of children and youth to live free of all forms of violence; and (4) to prevent or dampen maltreatment-related impairment via an increased focus on resilience. Evidence-based parenting programs exist and, given the broad range of impairment, it is severely costly to not implement these from a public health perspective.[55-58]

A chaotic, violent, antagonistic home life is maltreating in a persistent way for children and represents a toxicity to child and adolescent development. Transition from the home, such as quality preschool experiences, formal school entry, and increasing autonomy in adolescence provide opportunities to realign emotion-focused learning and orient towards positivity and healthy coping. Resilience-oriented programming may be an innovation approach to dampening the impact of emotional maltreatment. Emotional maltreatment has been linked to lower optimism; however, the experience of positive life events may buffer this effect and increase dispositional optimism.[59] Research has demonstrated the effectiveness of positive schemas (i.e., the ability to focus on positive stimuli and ignore negative, or emotionally taxing stimuli) in promoting resilience and interrupting the trajectory from childhood emotional maltreatment to poor mental health (e.g., depression).[60,61] These findings underscore an opportunity to emphasize safe, social relationship-building and to embrace service systems as partners in promoting wellbeing and resilience. Better life outcomes occur when violence in the personal and home environment ceases and positive experiences and opportunities increase. Emotional maltreatment is a preventable form of child maltreatment, and may yield sizeable dividends, given its prevalence.

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Prevention of Child Maltreatment and Associated Impairment

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Introduction

Child maltreatment encompasses four main types of abuse – physical, sexual, emotional abuse and neglect. More recently, exposure to intimate partner violence has also been identified as a form of child abuse. Child maltreatment is a significant public health and social welfare problem, in both high- and low-income countries and effective methods of prevention have begun to be identified during the past two decades.

Subject

Significant numbers of children experience abuse with prevalence levels varying by maltreatment type, gender and setting. The most recent review of prevalence studies concluded as follows: (n.b. the median or 50th percentile in addition to the 25th to 75th centile are presented, which means that 50%, 25% and 75% respectively of the values are below these centiles:

"Sexual abuse is the most commonly studied form of maltreatment across the world with median (25th to 75th centile) prevalence of 20.4% (13.2% to 33.6%) and 28.8% (17.0% to 40.2%) in North American and Australian girls respectively, with lower rates generally for boys. Rates of physical abuse were more similar across genders apart from in Europe, which were 12.0% (6.9% to 23.0%) and 27.0% (7.0% to 43.0%) for girls and boys respectively, and often very high in some continents, for example, 50.8% (36.0% to 73.8%) and 60.2% (43.0% to 84.9%) for girls and boys respectively in Africa. Median rates of emotional abuse were nearly double for girls than boys in North America (28.4% vs 13.8% respectively) and Europe (12.9% vs 6.2% respectively), but more similar across genders groups elsewhere. Median rates of neglect were highest in Africa (girls: 41.8%, boys: 39.1%) and South America (girls: 54.8%, boys: 56.7%) but were based on few studies in total, whereas in the two continents with the highest number of studies, median rates differed between girls (40.5%) and boys (16.6%) in North America but were similar in Asia (girls: 26.3%, boys: 23.8%).[1]"

The consequences of such maltreatment are wide-ranging with a significant impact on morbidity and mortality. In the U.S. for example, over 2000 children die due to abuse and neglect every year, with 86% of all maltreatment deaths being under the age of 6 years and 43% being infants less than one year of age.[2] The long-term consequences for survivors include wide-ranging mental health problems such as depression, drug and alcohol misuse, risky sexual behaviour, and criminal behaviour, all of which continue into adulthood.[3] The societal consequences of abuse are also high in terms of both direct (e.g., services to identify and respond to child abuse) and indirect costs (e.g., services to deal with associated problems such as mental health problems;

substance misuse; criminality, etc.).[3]

The high prevalence and serious consequences of child maltreatment point to the importance of effective prevention and treatment programs. Preventive strategies focus on a) primary prevention, which is aimed at intervening before abuse has been identified and utilizes two types of approach – population and targeted; b) prevention of recurrence of abuse after it has been identified; and c) prevention aimed at reducing associated impairment.

Problems

One of the main difficulties associated with identifying what is effective in preventing child maltreatment is a paucity of rigorous research designs that can be applied to the field of assessing program effectiveness. There is also wide variation in the measurement of outcomes and an over-reliance on parental self-report and proxy measures of outcome. Within low-income countries there is a lack of rigorous research across all types of abuse and prevention levels.

Research Context

Although child maltreatment is a significant public health problem both in terms of the individual and societal consequences, there is a limited body of research that explicitly addresses prevention, and much of the available evidence focuses on secondary/tertiary (i.e., intervening once abuse has occurred) rather than primary prevention. Similarly, much of the available research within primary prevention focuses on approaches that target high-risk groups as opposed to universal or population-based approaches.

Key Research Questions

The key research questions in relation to the prevention of child maltreatment focus on both the effectiveness and cost-effectiveness of preventive approaches and address the four main types of maltreatment in terms of the different levels of prevention highlighted above. Other questions focus on the specific approaches that are best suited to the different population groups that pose a risk in terms of child maltreatment (e.g., parents with serious mental illness, or who are abusing drugs; or for whom intimate partner violence is the main issue); and whether interventions that have been found to be effective in high-income countries can be translated to low-resource settings, and what cultural adaptation is needed.

Key Research Results

Part (a) of this section describes evidence-based interventions at the three different levels of prevention referred to above – primary prevention; prevention of recurrence, and prevention of impairment. Part (b) describes possible intervention strategies that go beyond the level of intervention.

a. Interventions for prevention

Primary prevention

There is, to date, limited evidence of the effectiveness of population-based interventions in high-income

countries for the prevention of child maltreatment. One promising intervention appears to be population-based Triple P involving the delivery of Triple P professional training for the existing workforce, in addition to the delivery of universal media and communication strategies.[4]

The research also suggests that a number of targeted primary preventive interventions have potential in high-income countries. Although home-visiting is not uniformly effective, the Nurse-Family Partnership has been found to have the greatest number of benefits in terms of reducing the risk of child maltreatment.[5]

Other primary preventive approaches that have been shown to have promise in high-income settings include hospital-based educational programs to prevent abusive head trauma, alongside enhanced paediatric care, for families of children at risk of physical abuse and neglect.[4] Although school-based educational programs appear to be effective in improving children's knowledge and protective behaviours, it is not currently known how effective they are in preventing sexual abuse.[6]

There is limited evidence available regarding the effectiveness of primary preventive approaches in low- and middle-income countries (LMICs), most of which is focused on middle- rather than low-income settings, and in many cases involves the adaptation of interventions developed in high-income countries.[7] Promising approaches include home visits (via existing health services; health clinics; or as stand-alone interventions) and group-based delivery (in community settings or work places), by paraprofessionals or professionals, with limited evidence currently of the effectiveness of intervention by lay individuals.[7]

Prevention of recurrence

There is also limited evidence available concerning what works to prevent the recurrence of maltreatment.8 Parent-Child Interaction Therapy (PCIT), a behavioural skills training intervention, has been found to be effective in preventing the recurrence of child physical abuse, and home-based training such as SafeCare can also produce small reductions in the recurrence of child maltreatment for preschool children.[8] There is also some evidence that multisystemic therapy can lead to small reductions in recurrence for children (aged 10-17 years) exposed to physical abuse.[8] There is no randomized controlled trial evidence available addressing what works to prevent recidivism of the other types of abuse,[8] or that are effective in LMICs.[7]

Prevention of impairment

The research suggests that the prevention of impairment requires a thorough assessment of the child and family. Evidence regarding the reduction of mental-health problems for maltreated children in high-income countries suggests that psychological interventions, such as cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT), should be considered for children and adolescents who have been exposed to maltreatment and are experiencing emotional disorders, and that trauma-focused CBT should be provided for children who have been sexually abused and are suffering with post-traumatic stress symptoms.[5] There is also some evidence of the benefit of child-parent psychotherapy, and trauma-focused CBT for children with intimate partner violence-related post-traumatic stress disorder (PTSD) symptoms.[5] There is no English language evidence from RCTs currently available regarding the prevention of impairment in children in LMICs.

For maltreated children who need to be removed from the parental home

The research shows that in high-income countries, foster care can lead to benefits across a range of domains including antisocial behaviour, sexual activity, school attendance and academic achievement, social behaviour, and quality of life, compared with children who remain at home or who reunify following foster care, and that enhanced foster care can produce even better outcomes in terms of fewer mental and physical health problems.[4] There is no English language evidence from RCTs currently available regarding effective alternatives to parental care for maltreated children in LMICs.

b. Strategies for prevention

The Spectrum of Prevention describes seven levels at which prevention activities can take place, and moves beyond individual services and community education.[9] It encourages creative and effective prevention projects, and can help communities develop activities that have a greater chance of success as a result of the fact that they complement the strengths that already exist within a community.[9]

Research Gaps

More research is needed to identify approaches and strategies that can be used as part of both a primary population-based approach (e.g., available to everyone), and also targeted-approaches (e.g., with high-risk groups) to the prevention of child maltreatment. Population-based strategies include wide-ranging changes to the legal systems that protect children better from the use of aversive parenting methods (e.g., physical punishment), and the application of population-based strategies to the delivery of evidence-based parenting programs (e.g., population-level Triple-P). Further evaluation is needed of the value of targeted approaches such as video-interaction guidance, attachment- and mentalization-based interventions, and parent-infant psychotherapy, all of which are early interventions aimed at improving parent-infant/toddler interaction in high-risk families.

There is a need for further long-term follow-up particularly of interventions that are delivered during the first three years of a child's life, and for the use of multi-method and multisource approaches to the assessment of maltreatment.[10] There is also a need for further research into potentially beneficial approaches to the prevention of recurrence and impairment, where once again, the evidence is limited. Such research should build on what is already known about what works.

Further research is also needed on the effectiveness of programs in LMICs, including the extent to which existing evidence-based programs can be adapted for use within low resource settings, and the possibility of using lay providers to deliver such interventions.[7] Other research issues in these settings include the need for more complete reporting, increased standardization of outcomes and use of validated measures, and more studies focusing on older children.[7] Further research is also needed to identify interventions to prevent recurrence and impairment among maltreated children.

Conclusions

Given the high prevalence of child maltreatment and the serious consequences in terms of its impact on the lives of the individuals concerned, their families, and society more generally, it is important that effective

methods of prevention and intervention are identified. Although there is limited research available in terms of what works to prevent child maltreatment, there have been significant gains over the past 20 years in terms of the development of new approaches.

Implications for Parents, Services and Policy

The research suggests that strategies to prevent maltreatment should begin early and encompass both population-wide approaches that aim to provide pregnant women and parents of new babies with access to wide-ranging universal support (such as population level Triple-P), alongside the provision of targeted approaches (i.e., intensive home visiting such as Nurse-Family Partnership) to families who face additional risks that increase the vulnerability of the baby. Prevention of recurrence and impairment should include the provision of interventions that target parents (post-shelter counseling), the dyad (e.g., parent-infant psychotherapy and PCIT), and child-focused interventions (e.g., school-based educational programs, trauma-focused CBT). Foster care and enhanced foster care programs can also lead to improved outcomes for children.

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Child Maltreatment and its Impact on Psychosocial Child Development: Epidemiology

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Introduction

Child maltreatment is a significant threat to the healthy development of children. Understanding the scope and severity of maltreatment is critical in developing clinical interventions and social policies to protect children at risk and to treat children who have already been victimized. The following article describes the incidence, prevalence and severity of child maltreatment and provides a brief discussion of implications for policy and practice.

Definitions

Child maltreatment is the broad term used to describe abusive and neglectful acts perpetrated by adults or older youth against children. These fall into four broad categories: physical abuse, sexual abuse, neglect and emotional maltreatment. Physical abuse ranges from severe assaults against children that can permanently injure or kill children to abusive physical punishment to shaking infants. Sexual abuse includes intercourse, fondling, acts of exposure, sexual soliciting and sexual harassment. Neglect refers to a failure to supervise or protect a child or to meet a child's physical needs. Neglect often occurs in a context of extreme poverty where parents may not have the resources or supports needed to meet a child's needs. Emotional maltreatment includes extreme or habitual verbal abuse (threatening, belittling, etc.), and systematic lack of nurturance or attention required for a child's healthy development. Children's exposure to intimate partner violence (IPV) is increasingly being recognized as either a form of emotional maltreatment or a separate category of exposure.

Annual Incidence

Child maltreatment incidence statistics are tracked in Canada through the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS), a periodical survey of cases investigated by provincial and territorial child-protection authorities.[1] The 2008 cycle of the study found that an estimated 235,497 maltreatment related investigations involving children under 16 years of age were conducted in Canada in 2008, and that child maltreatment had been substantiated for 85,440 of these children, a rate of 14.19 victims per 1,000 children.[a]

Over a third of these children(31,506), were under six years of age.[1] Rates of victimization were highest for younger children (17.10 per 1,000 children under one year of age compared to 14.57 for those under five), but

there was no clear pattern by sex (see bar charts).

It is difficult to make direct comparisons between incidence rates in Canada and in other countries because of differences in reporting and investigation procedures. The rate of victimization reported in the United States in 2008 was 10.3 per 1000 children,[2] whereas in Australia, the rate of victimization for fiscal year 2008-09 was 6.9 per 1000 children.[3]

Childhood Prevalence

Prevalence studies measure rates of victimization during childhood, as opposed to incidence statistics that measure rates of victimization during a specific year. Results from a Canada-wide health survey show that 32% of respondents aged 18 years and older reported some type of child abuse, including physical abuse (26.1%), sexual abuse (10.1%) and exposure to intimate partner violence (7.9%).[4] Women were more likely than men to report sexual victimization (14.4% v. 5.8%). These findings are consistent with results from surveys conducted in Ontario[5] and Quebec.[6] Notably, the Quebec survey found that only 21.2% of adults reported disclosing their victimization within a month of the first abusive event.

Injury and Death

Physical injuries due to maltreatment are relatively rare. The 2008 CIS found that physical injuries were noted in 8% of the 26,339 cases of substantiated maltreatment involving newborns to five-year-olds. In most instances these were bruises and scrapes that did not require medical attention. Injuries requiring medical attention were noted in 4% of cases involving children one to five years of age. Injuries were generally more serious for children under one year of age: 8% required medical attention and head trauma was noted in 3% of cases.

Severe abuse leading to injuries is of particular concern in situations involving young children because of the elevated risk of permanent harm or death during the first four years of life. Children under five are at highest risk of being killed by a parent: 50% of children from birth to 17 who are killed by a family member are under four years old.[7] Rates of child and youth homicides perpetrated by family members have been declining: the rate of family-related homicide against children and youth decreased by 18%, from 3.4 in 2007 to 2.8 per 1 million population in 2017.[8]

Emotional Harm

Most cases of maltreatment reported to child welfare services involve situations where children have already suffered some sort of emotional harm or are at significant risk of experiencing emotional harm. Young children are particularly vulnerable to a range of long-lasting negative cognitive, psychosocial, and behavioural outcomes, including learning problems, problems relating to peers, depression, anxiety or aggression.[9] Maltreatment of young children changes the way they interpret interpersonal interactions, which in turn affects the nature of relationships with family and peers.[10] Of particular concern is the growing evidence of neurobiological effects of maltreatment, especially emotional maltreatment and neglect, during early childhood.[11]

Trends

Child maltreatment is increasingly recognized as a public health problem of growing concern. The rate of

maltreatment has increased by over 50% from 9.21 substantiated investigations per 1,000 documented in 1998, to 14.19 in 2008.[1] This increase appears to be primarily driven by broadening mandates and greater recognition of child maltreatment amongst professionals working with children, in particular with respect to the rate of neglect which has almost doubled, and the rate of exposure to IPV which has more than tripled.[12,13] In contrast, the rate of substantiated sexual abuse has decreased by over 50% between 1998 and 2008. The increase in cases of exposure to IPV has primarily been driven by a dramatic shift in the response of the police, health professionals and school personnel, who account for nearly 90% of all domestic violence reports. The decrease in reports of child sexual abuse is more difficult to interpret. While the decrease in reports could be attributed to a decrease in rates of victimization in the population, there also is evidence that the decline reflects changes in reporting patterns and investigation procedures.[14]

Implications for Policy and Practice

Child maltreatment is a major health problem, affecting over 85,000 children a year across Canada. Abused and neglected children are at very high risk of developing long-term social, emotional and cognitive problems. The response to these children has, however, been fragmented. Beyond the universal introduction of mandatory reporting laws across Canada, few treatment and prevention programs have been systematically developed to meet the needs of these children. An examination of rates of victimization reveals a diverse population, ranging from cases of severe physical abuse requiring urgent response to complex cases of neglect and exposure to domestic violence, where the role of child protection authorities may need to be reconceptualized. Under the continued pressure of increasing caseloads, child welfare service-providers are seeking more effective models for collaborating with other service-providers.[12,13]

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Note:

[a] In another 17,918 cases, maltreatment could not be substantiated, but remained suspected. In 71,053 cases, maltreatment was unsubstantiated, and 61,431 investigations were for future risk of maltreatment where no specific allegations of past incidents of maltreatment had been made.

Child Sexual Abuse: An Overview

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Introduction

Child sexual abuse (CSA) is a form of maltreatment that is recognized globally as a serious human rights violation and a major public health concern. This paper will provide an overview of the state of knowledge on CSA.

Subject

It is now recognized that the definition of CSA includes both contact and non-contact abuse. CSA comprises any sexual activity perpetrated against a minor by threat, force, intimidation or manipulation. The array of sexual activities includes fondling, inviting a child to touch or be touched sexually, intercourse, rape, incest, sodomy, exhibitionism, or involving a child in prostitution or pornography.[1] There is a general consensus that CSA is a complex phenomenon occurring for multiple reasons, in various ways, and in different relationships within families, peer groups, institutions, and communities.[2] Two important overlapping unresolved issues include the lack of a conceptual model of CSA and the absence of a shared definition or understanding of what constitutes CSA worldwide.

Scope of the Problem

Most studies emphasize that the full extent of CSA perpetration remains unknown.[1,3] It is difficult to determine given differences in the way data is collected,[4] as well as the reticence of most children to disclose the abuse.[5]

Disclosure of traumatic events such as CSA can often be a very complex, iterative life-long process.[6] Victims of CSA often delay reporting, or never tell.[5] For example, in a review by Finkelhor[7] only about half of survivors across all studies had disclosed the abuse to anyone. In another study, the vast majority of survivors (93%) did not report the abuse to authorities prior to the age of 15.[8]

In a 2013 systematic review and meta-analysis of recent studies worldwide, CSA prevalence rates were found to be 8 to 31% for girls and 3 to 17% for boys. Forced intercourse was self-reported by 9% of girls and 3% of boys.[9] In contrast, incidents of CSA reported annually to formal, official bodies such as child protection services is drastically lower (e.g., .43% in Canadian child protection systems;[10] 2.4% in U.S. child protection and community agencies).[11] Clearly, official reports to authorities underestimate the extent of CSA; in another worldwide CSA prevalence meta-analysis, rates were more than 30 times higher in self-report than official-report studies (12.7% versus 0.4%).[12]

Key Research Questions

For the past few decades, several questions have been central in guiding CSA research. These include: What are the risk factors for CSA? What are the mental health outcomes of CSA? What are the protective factors that make some children less likely to experience impairment following CSA exposure? What are the most effective prevention, assessment and treatment strategies?

Recent Research Results

Female children are about two times more likely to be victims of CSA than males.[12] There is a strong likelihood, however, that boys are more frequently abused than the ratio of reported cases would suggest given their probable reluctance to report the abuse.[13] Risk for CSA rises with age, with the highest number of victims in the 12 to 17-year age range. Girls are considered to be at high risk for CSA starting at an earlier age and of longer duration, while risk for boys peaks later and for a briefer period of time.[1]

CSA is a major risk factor for developing a host of negative consequences in both childhood and adulthood. Victims have been shown to experience more post-traumatic stress and dissociative symptoms than non-abused children,[14] as well as more depression and conduct problems.[15] They engage more often in at-risk sexual behaviours.[16] Victims are also more prone to abusing substances,[17] and to suicide attempts.[18] These mental health problems are likely to continue into adulthood.[19] CSA victims are also more at risk than non-CSA youth to experience violence in their early romantic relationships;[20] women exposed to CSA have a two to three-fold risk of being sexually revictimized in adulthood compared with women without a history of CSA exposure.[21]

However, about one third of victims may not manifest any clinical symptoms at the time the abuse is disclosed.[22] This can be explained, in part, by the extremely diverse characteristics of CSA which lead to a wide range of potential outcomes. Also, several factors influence the resilience of CSA victims; for example, children who receive support from their non-offending parents[23] and those who have not experienced prior abuse[24] seem to fare better. In all cases, however, early assessment and where indicated, intervention to address the negative outcomes, are important.

In the area of assessment, two forensic protocols have undergone considerable evaluation. These include the National Institute of Child Health and Human Development (NICHD) Structured Interview Protocol and the Sexual Assault Nurse Examiner (SANE) Model.

- The use of a structured investigative protocol, such as the NICHD model, specifies that police officers receive extensive training to elicit detailed information from CSA victims in a non-suggestive manner. This protocol clearly enhances the quality of interviews and facilitates the assessment of credibility by child investigators.[25]
- The SANE nurses provide, usually in the context of a hospital emergency unit, a first response that addresses victims' emotional and physical needs while gathering the forensic evidence that could potentially lead to prosecution of the person responsible for the abuse. The effectiveness of SANE in regard to forensic evidence collection and prosecution rates in CSA cases involving children has been demonstrated.[26]

In terms of interventions for reducing impairment associated with CSA, a recent meta-analysis found that treatment is effective in reducing PTSD symptoms as well as externalizing and internalizing problems.[27] Of the handful of evidence-based treatments, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is the most established treatment for children who have experienced CSA and present with post-traumatic stress disorder (PTSD) symptoms.[28] Randomized controlled trials have shown this treatment to be effective in improving participant symptomatology as well as parenting skills and children's personal safety skills, even when the duration of the program was as short as eight weeks.[29] Sustained improvement following TF-CBT has been shown for anxiety, depression, sexual problems and dissociation at the 6-month follow-up and in PTSD and dissociation at the 12-month follow-up.[30,31]

Although school-based educational programs are widely disseminated and promoted as a primary prevention strategy, little evidence exists that they are effective in preventing actual exposure to CSA; they appear to improve children's knowledge and protective behaviours and may increase the likelihood of disclosure, but it is unknown whether they prevent the occurrence of CSA.[32]

Research Gaps

Two main gaps are worth highlighting: First, since most CSA victims remain unidentified, current knowledge is likely biased in its focus on information from victims where CSA has been detected; further investigation is needed to understand the variable ways in which children exposed to CSA present. Second, there is a need to identify additional evidence-based approaches for assessment, treatment and prevention of CSA.

Conclusions

While there is now a general consensus regarding the definition of CSA, the magnitude of the problem remains difficult to estimate given the differences in data collection systems. A 2011 meta-analysis on CSA prevalence showed that 12.7% of adults were sexually abused in their childhood or teenage years, with females and older children showing an increased risk. CSA is a major risk factor in the development of short- and long-term negative consequences, such as depression, PTSD, and substance abuse, although not all victims experience impairment. Two forensic protocols – the NICHD Structured Interview Protocol and the SANE Model – are well established in the field. The most effective treatment of children exposed to CSA and presenting with PTSD symptoms is TF-CBT. Future research should focus on developing strategies to facilitate the disclosure and reporting processes of CSA, to better identify the needs of CSA victims, and to develop prevention strategies.

Implications for Parents, Services and Policy

Beyond the broad range of deleterious health and social impacts of CSA, the lifetime economic costs have been estimated to be $9.3 billion.[33] To address this major public health problem, we should prioritize the development of strategies to prevent sexual abuse from happening in the first place and address the barriers to disclosure and reporting. Although the taboo of CSA might not be as prominent as a few decades ago, stigma as well as difficulty accessing services may still prevent victims from receiving necessary resources.

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